Name:______________________________DOB__________________

Address:

Telephone____

Emergency contact name & phone _______________________________

Occupation____

Baby's name_________________________DOB__________________

Post Natal History

Type of delivery: ☐ Vaginal ☐ C-Section

Have you had the all clear from your GP? Yes / No

Did you have : ☐ Episiotomy ☐ Stitches

Are you breastfeeding? Yes / No

Medical History

Please tick if you have experienced any of the following:

☐	Asthma	☐	Heart Problem	☐	Dizzy Spells
☐	Diabetes	☐	Migraines	☐	High Blood Pressure
☐	Hay Fever	☐	Pubic Pain	☐	Low Blood Pressure
☐	Epilepsy	☐	Chest Pains	☐	Hypoglycaemia
☐	Arthritis	☐	Vaginal Disorder	☐	Pelvic / Abs Cramps
☐	Allergies	☐	Blood Disorder	☐	Back or Joint Pain

If yes, please explain____

Any other information relevant to commencing an exercise class___________